child ABUSE & NEGLECT

A Handbook For Community Health Nurses

34-155 (3/87)

54134

CHILD ABUSE

AND

NEGLECT

A HANDBOOK FOR COMMUNITY HEALTH NURSES

This publication was funded by the Child Abuse Prevention Program of the Ontario Ministry of Community and Social Services

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April, 1987

ACKNOWLEDGEMENTS

Many individuals have committed their time and professional expertise to the completion of this handbook under the guidance of the Personal Health Services Managers, Department of Public Health. The handbook has also been reviewed by staff of the Suspect Child Abuse and Neglect (SCAN) program at the Hospital for Sick Children, the City Solicitor, and the Metro Special Committee on Child Abuse. The Child Abuse Work Group wishes to express a sincere thank you to all of them.

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PREFACE

The Child Abuse Work Group, City of Toronto, Department of Public Health is pleased to present this handbook for the use of Community Health Nurses. We believe that the material contained provides a comprehensive guide to the identification, documentation, reporting and case management of child abuse and neglect.

Child abuse and neglect is not a new phenomenon - it has existed in every human society throughout history. However, the understanding of the maltreatment of children is still in its infancy. As health care professionals we may be directly or indirectly involved in child abuse situations, but each of us has a responsibility to be informed. This handbook is an attempt to respond to staff learning needs identified in the Child Abuse Needs Survey conducted during February and March, 1984. The major areas of concern were:

- definitions of the different categories of child abuse and neglect
- role expectations for various staff positions
- warning indicators
- interviewing skills and techniques
- family assessment guidelines
- reporting procedures
- documentation guidelines
- case management
- court procedures.

It is hoped that the information provided will be beneficial to all levels of staff and will precipitate ongoing learning and interest in the prevention of a serious social problem.

Health Units outside the City of Toronto should feel free to add or change information to make this handbook relevant to their areas. The sections entitled "Role Expectations", "Reporting Procedure", "Documentation Guidelines" and "Resources", are examples of where such additions or amendments may be made. The Registered Nurses Association of Ontario Handbook "Child Abuse, Neglect and Deprivation" may be used in conjunction with this handbook.

Although this handbook is written for Community Health Nurses, we recognize that child abuse and neglect, by their nature, require a multi-disciplinary approach.

For purposes of this handbook, we have taken the liberty of using the male pronoun when referring to the 'child' or the 'parent(s)', and the female pronoun when referring to the 'Community Health Nurse'. 'Parent' is used synonymously with 'caregiver', or 'guardian'.

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INTRODUCTION

INTRODUCTION

It is not fully appreciated that many individuals responsible for the care of infants and children may permit trauma and be unaware of it, may recognize trauma but forget or be reluctant to admit it, or may deliberately injure a child and deny it. The fact that several thousand children in Ontario are neglected, abused, or sexually assaulted each year is beyond comprehension. Despite the unacceptability of this type of behaviour, many health care professionals remain uncertain about their role, about legal requirements, about agency procedures, and about possible courses of action and their outcomes.

Child abuse and neglect are not pathological states of an isolated child or family - they are complex social problems affecting the child, parents, siblings, relatives, future children and grandchildren, as well as the community and society at large. Research has shown that child abuse and neglect most often occur in a dysfunctional family environment within a stressful context of social isolation, poor housing, financial difficulty, marital discord. Abusive persons represent all socio-economic levels, ages, religious groups, races and nationalities. There is no evidence of a given set of family, parent or child characteristics that are always present in situations of child abuse and neglect. It must be recognized that a number of factors may combine to set the abusive pattern. Only with this understanding can treatment approaches begin to address some of the contributing situational factors.

For an abusive act to occur, three criteria must be met:

1. There must be a person with the potential to abuse. Every person may have that potential at particular moments.

2. There must be a child. In cases of physical or emotional abuse and neglect, this is generally a special child - one who is seen differently by his parents, one who fails to respond in the expected manner, or one who really is different, e.g. developmentally delayed, hyperactive, depressed, has a congenital anomaly.

3. There must be some form of crisis, or a series of crises, that sets the abusive act into motion. This can be a seemingly minor event or it may be more significant. In cases of sexual abuse, this criterion may not be present.

DEFINITIONS OF CHILD ABUSE AND NEGLECT

DEFINITIONS

CHILD ABUSE

The legal definition of "a child in need of protection" is presented in the Reporting Procedure. A general working definition of child abuse is:

> Any act of commission or omission by individuals, institutions, or society as a whole, and any conditions resulting from such acts or inactions, which deprive children of equal rights and liberties and/or interfere with their optimal development, constitute abusive or neglectful acts or conditions (1).

PHYSICAL ABUSE

Physical abuse includes any non-accidental form of injury which is inflicted on a child by a caregiver. The injury may range from bruises and cuts to fractures and internal injuries.

NEGLECT

Neglect involves acts of omission on the part of the caregiver; lack of provision for the basic needs of a child, such as shelter, food, education, medical and dental care, safety, and supervision. Polansky defines it as follows:

> Child neglect may be defined as a condition in which a caregiver responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities (2).

FAILURE TO THRIVE SYNDROME (NON-ORGANIC)

Failure to thrive "...describes a child who has sometime during the first three years of life suffered a marked retardation or cessation of growth." (3). It is characterized by an inadequate weight gain (weight values falling to the third percentile or below), and more seriously by a lag in linear growth and head circumference. The most important cause is a lack of nurturing care.

EMOTIONAL ABUSE

Emotional abuse is very difficult to define. It occurs when the caregiver is unwilling or unable to provide the warmth, affection, and nurturance necessary for growth and development of the child. This absence of a nurturing environment combined with verbal abuse can be particularly devastating. Emotional abuse may be evident through acts of commission or omission. Acts of commission include criticism, constant screaming, excessive performance demands, belittling, scapegoating and verbal rejection. Acts of omission include ignoring, passive rejection, withholding affection, and lack of holding and cuddling.

SEXUAL ABUSE

Sexual abuse involves contacts or interactions between a child and another person in which the child is used for the sexual gratification of that person or another person, and where the perpetrator is in a position of power or control over the child. It includes a wide range of activities from permitting or exposing a child to sexual acts such as prostitution, to actual exposure, fondling, masturbation and intercourse (4). It also includes exploitation of a child for pornographic purposes and seduction with consent extorted by bribery or threats of harm to the child or someone else.

MUNCHAUSEN'S SYNDROME BY PROXY

Munchausen's Syndrome By Proxy is the victimization of a child through parentally induced or fabricated illness. Thus the child may be subjected to unnecessary investigation and treatment.

CAO-GIO - SCRATCHING THE WIND

The practice of cao-gio (pronounced cow you) or "scratch the wind" is a Southeast Asian folk remedy. It involves soaking the skin of a sick child in menthol oil and scratching along the spine, back, base of the neck or between the ribs until welts appear. It is believed the patterned scratching will rid the body of "bad winds" that cause the illness. Asian parents sometimes use cao-gio when they are unable to reach a doctor for conventional treatment.

A great deal of discretion has to be brought to bear when making a judgement in a specific case. It has to be taken into account how long the family has been in Canada, their origins, the family's feeling toward the child and exposure to Canadian society and medical practice.

PROFESSIONAL ROLE EXPECTATIONS

PROFESSIONAL ROLE EXPECTATIONS

These expectations are specific to positions within the City of Toronto, Department of Public Health, and may be adapted to individual Health Units as necessary.

DEFINITIONS

Primary Prevention:

The action taken to reduce the incidence of new cases of child maltreatment by:

1) strengthening the positive coping skills of the individual (e.g., parenting education) and/or

2) changing the environment and social attitudes (e.g., promoting community conditions for greater child safety) to eliminate/decrease the potential for abuse.

Advocacy:

Actions taken towards the goal of promoting the well-being of children. Actions include:

1) identifying needs

2) developing goals

3) working through the political process to achieve goals

4) developing support systems for the maintenance of the goals, and

5) adopting a broad perspective to promote well-being, rather than focusing on individual family problems.

Case Management:

The identification of the problem and appropriate intervention including:

1) assessment

2) action

3) plan

4) evaluation.

ROLE EXPECTATIONS FOR PERSONAL HEALTH SERVICES STAFF

The depth or level of knowledge and skill expected will vary with the person's job title. In an attempt to come to terms with this, a coding system has been developed.

R - Responsibility: Ultimate responsibility for staff who perform the activity.
G - Guidance: No direct performance of the activity but guides or supervises staff who perform the activity.
A - Active Participation: Direct performance of the activity.
RS - Role-Specific Participation: Performance of activity is limited to area of specialty or degree of involvement.

ROLE EXPECTATIONS
GENERAL
1. Recognition of personal values, attitudes and behaviours regarding child abuse and their potential effect on professional work with families.
2. Awareness of cultural differences in family dynamics.
PRIMARY PREVENTION ROLE
(Our definition of primary prevention includes what some people might call secondary prevention, i.e., screening programs, respite services, crisis day care and parents' self-help groups.)
1. Preconception, prenatal, intrapartum and postpartum identification of persons prenatally, perinatally and postpartum who may be at risk for potential abuse.
2. Identification of family and environmental stressors.

PERSONAL HEALTH SERVICES STAFF

Manager	A	A											R	R
Nursing Supervisor	A	A											G	G
Multidisciplinary Team Supervisor	A	A											G	G
Area Educational Consultant	A	A											RS	RS
Mental Health Nurse	A	A											A	A
Public Health Nurse	A	A											A	A
Registered Nurse	A	A											A	A
Registered Nursing Assistant	A	A											RS	RS
Healthiest Babies Possible Dietician	A	A											RS	RS
Nutritionist	A	A												
Family Planning Community Worker	A	A											RS	RS
Sexually Transmitted Diseases Nurse	A	A											RS	RS
Tuberculosis and Respiratory Diseases Nurse	A	A											RS	RS
Immunization Nurse	A	A												

ROLE EXPECTATIONS
3. Implementation of stress reduction techniques (e.g., increasing positive problem-solving skills).
4. Identification of family's present use of resources/support systems (e.g., church, relatives).
5. Assessment of the influence of these resources/support systems on family members.
6. Solicitation of appropriate resources for families.
7. Evaluation of the use and influence of these resources on the family.
8. Role-modelling nurturing child-rearing behaviours, coping skills and problem-solving techniques.
9. Education of children regarding preparation/guidance skills to promote self-protection and self-worth.
10. Provision of family-centred care while actively listening to the needs and acknowledging the rights of each family member.
11. Utilization of an empathic response to individual concerns.
12. Education of prospective parent/parents regarding: growth and development concerns and the child's related need for optimum nutrition, safety and emotional needs, while reinforcing positive parenting behaviours.
13. Collaboration with other agencies and professionals when appropriate, i.e., joint development of high risk indicators, sharing information, etc.

PERSONAL HEALTH SERVICES STAFF

Manager	Nursing Supervisor	Multidisciplinary Team Supervisor	Area Educational Consultant	Mental Health Nurse	Public Health Nurse	Registered Nurse	Registered Nursing Assistant	Healthiest Babies Possible Dietician	Nutritionist	Family Planning Community Worker	Sexually Transmitted Diseases Nurse	Tuberculosis and Respiratory Diseases Nurse	Immunization Nurse
R	G	G	RS	A	A	A		RS		RS			
R	G	G	RS	A	A	A		RS		RS			
R	G	G	RS	A	A	A		RS		RS			
R	G	G	RS	A	A	A		RS		RS			
R	G	G	RS	A	A	A		RS		RS			
A	A	A	A	A	A	A	A	A	A	A	A	A	A
R	G	G	RS	A	A	A	RS		RS	A	RS		
G	G	G	RS	A	A	A	RS	RS		RS	RS	RS	
A	A	A	A	A	A	A	A	A	A	A	A	A	A
G	G	G	RS	A	A	A	RS	RS	RS	RS			
A	A	A	A	A	A	RS		RS	RS	RS	RS		

ROLE EXPECTATIONS
14. Continual application of the nursing process to each family situation with revisions as necessary.
ADVOCACY
1. Identification of individual, family and community needs.
2. Development of community-based approaches to meet those needs, within the Department of Public Health or with other agencies.
3. Provision of public education regarding child abuse prevention, identification, reporting, and treatment resources.
4. Encouragement and/or provision of professional education regarding child abuse prevention, identification, reporting and treatment resources.
5. Liaison with multidisciplinary/interprofessional committees concerned with the issues of child abuse.
6. Consultation with lawyers to protect legal rights of family members (e.g., Official Guardian; Justice for Children).
7. Solicitation of departmental and government support for community issues and programs related to child abuse prevention and treatment (e.g., parenting programs, improved housing conditions).
CASE MANAGEMENT ROLE
1. Identification of situation of possible child neglect or abuse.
2. Assessment of each situation on individual, family and community levels (e.g., growth and development of children, family functioning and use of community resources).

PERSONAL HEALTH SERVICES STAFF

Manager	Nursing Supervisor	Multidisciplinary Team Supervisor	Area Educational Consultant	Mental Health Nurse	Public Health Nurse	Registered Nurse	Registered Nursing Assistant	Healthiest Babies Possible Dietician	Nutritionist	Family Planning Community Worker	Sexually Transmitted Diseases Nurse	Tuberculosis and Respiratory Diseases Nurse	Immunization Nurse
G	G	G	RS	A	A	A	A				A	A	
A	A	A	A	A	A	A	A	A	A	A	A	A	A
A	A	A	A	A	A	RS	RS	RS	RS	RS	RS	RS	RS
RS	RS	RS	RS	A	A	RS	RS			RS	RS		
A	A	A	A	A	A	RS				RS	RS		
A	A	A	A	A	A	RS				RS	RS		
G	RS	RS	RS	A	A	RS				RS	RS		
A	A	A	A	RS	RS	RS		RS	RS	RS	RS		
RS	RS	RS	RS	A	A	A	A	A	RS	A	A	A	A
G	G	G	RS	A	A	A		RS		RS	RS	RS	RS

ROLE EXPECTATIONS
3. Development with the family, of an intervention plan, including specific short-term and long-term goals.
4. Documentation and reporting of essential facts of each case according to the Child and Family Services Act, 1984 and Departmental requirements.
5. Consultation with colleagues, supervisors, other agencies and legal counsel to provide optimal case management.
6. Participation in establishing goals for intervention.
7. Evaluation of the case situation and, if appropriate, continuation of provision of service to the family.
8. Continuation of interprofessional involvement to provide a consistent, collaborative approach to case management and follow-up.

PERSONAL HEALTH SERVICES STAFF

Manager	Nursing Supervisor	Multidisciplinary Team Supervisor	Area Educational Consultant	Mental Health Nurse	Public Health Nurse	Registered Nurse	Registered Nursing Assistant	Healthiest Babies Possible Dietician	Nutritionist	Family Planning Community Worker	Sexually Transmitted Diseases Nurse	Tuberculosis and Respiratory Diseases Nurse	Immunization Nurse
G	G	G	RS	A	A	RS		RS		PS	RS	RS	RS
RS	G	G	RS	A	A	A	A	A	PS	A	A	A	A
RS	RS	RS	RS	A	A	A	A	A	RS	A	A	A	RS
R	G	G	RS	A	A	RS		RS	RS	RS	RS	RS	
R	G	G	RS	A	A	RS		RS		RS	RS	RS	
R	RS	RS	RS	A	A	RS		RS	RS	RS	RS	RS	

WARNING INDICATORS FOR FAMILIES AT RISK

WARNING INDICATORS FOR FAMILIES AT RISK

Indicators are warning signals only, and when found alone or in various combinations, may mean that a neglectful or abusive situation exists. Their presence should be used as a guide in assessment and planning intervention. Some of these indicators appear in certain circumstances as a normal occurrence or accident in a "healthy" family. They should be considered in the context of the family/community.

A report must be made to the Children's Aid Society when there are reasonable grounds to suspect that a child is in need of protection.

The indicators of physical abuse are perhaps the most obvious. In assessing any injury, its location is significant. The nurse must be aware of the likelihood of a specific injury occurring in a specific location (see Diagram of Body Outline illustrating suspicious areas of injury). The indicators of neglect, emotional abuse and sexual abuse are perhaps harder to identify and are often ignored or interpreted as something other than abusive. It is therefore vital to be familiar with all of the indicators, recognizing that no list is exhaustive. Only by looking at a situation in its totality can a good assessment be done and a decision be made as to the significance of the indicators that are present.

The indicators have been categorized according to the following headings:

- perinatal indicators
- caregiver/family indicators
- child indicators

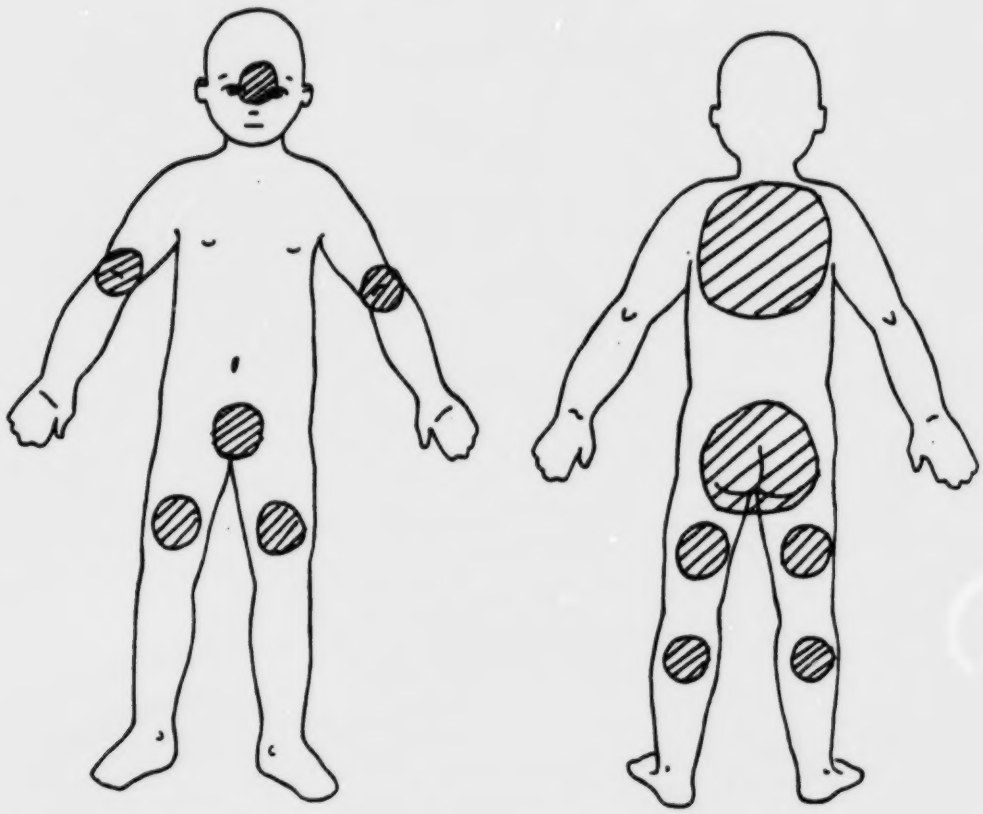
These categories are further subdivided into:

- characteristics of the parent(s) and/or caregiver(s)
- characteristics of the child (physical, behavioural, developmental, and other, according to age level)
- parent-child attachment
- parenting knowledge, beliefs, expectations, practices
- support systems
- family circumstances

ALTHOUGH MANY OF THE INDICATORS MAY APPEAR IN MORE THAN ONE LIFE STAGE, WE HAVE INCLUDED THEM ONCE ONLY, IN THE EARLIEST STAGE.

Diagram of Body Outline

The shaded areas are common sites of non-accidental injuries in children. They are, however, not all inclusive and suspicious injuries may be noted on other body areas.



WARNING INDICATORS FOR FAMILIES AT RISK

	PERINATAL INDICATORS		
	CHARACTERISTICS OF PARENT(S)/CAREGIVER(S)	CHARACTERISTICS OF CHILD	PARENT-CHILD ATTACHMENT
PRECONCEPTION & PRENATAL	- mother aged under 20 - chronic illness of mother - history of violent/ aggressive behaviour - dissatisfaction with present lifestyle - perceives pregnancy as very difficult - mother feels her health will suffer from childbearing or childrearing - intellectual impairment - mental health problems including depression or suicide attempt - excessive fear related to pregnancy, labour and delivery - fears cannot be dissipated - abuse of drugs/alcohol - child wanted to fill unmet needs in parent - evidence of low self esteem, particularly re: parenting ability - previous poor pregnancy outcome - history of previous involvement with Children's Aid Society due to another child's abuse/ neglect - history of parenting difficulties - inconsistent/absent prenatal care - inability to deal with stress - previous/present negative prenatal experience - preoccupation with physical complaints and with self		- pregnancy unplanned or unwanted - consideration of abortion/relinquishment - denial of pregnancy - perception of fetal movements as abusive or aggressive - obsessive preference regarding baby's sex - parent attributes negative characteristics to fetus - apparent lack of concern for the physical well-being of fetus as evidenced by refusal to make health/lifestyle changes - absence of nesting behaviour in third trimester

WARNING INDICATORS FOR FAMILIES AT RISK

	PERINATAL INDICATORS		
	PARENTING KNOWLEDGE, BELIEFS, EXPECTATIONS, PRACITCES	SUPPORT SYSTEMS	FAMILY CIRCUMSTANCES
PRECONCEPTION & PRENATAL	- perceives self as having, or experienced an abusive/neglectful upbringing - experienced harsh physical punishment during childhood - expresses a strong desire to parent in a manner different from own parents - unrealistic expectations of child (inaccurate knowledge regarding growth and development) - conflict between parents re: child-rearing practices - inappropriate attitudes regarding behaviour management - secrecy is prominent feature in family communication	- expresses dissatisfaction with spouse/mate relationship - chronic marital discord - chronic conflict with, or alienation from, one's own parent(s) - mate and/or family's reaction to pregnancy is negative or non-supportive - social isolation, lack of support person, no phone, outside interests or use of community resources - inability to relate with trust to helping professionals	- expresses concern that child will be "one too many"/"one too soon" - inadequate housing for family's needs - economic instability - recent death/loss of loved one - financial, health, social or interpersonal problems in the famiy - expresses inability to cope with present life circumstances - deprivation in family background (physical, emotional, social, financial, educational) - recent crisis

WARNING INDICATORS FOR FAMILIES AT RISK

PERINATAL INDICATORS			
	CHARACTERISTICS OF PARENT(S)/CAREGIVER(S)	CHARACTERISTICS OF CHILD	PARENT-CHILD ATTACHMENT
NATAL	* - difficult/traumatic delivery - mother experiences excessive discomfort, fatigue, drug effects or physical complications immediately following delivery	- prematurity - congenital anomaly - mental retardation - condition necessitating separation from parents - unresponsive infant	* - parent looks distressed, disappointed - lack of interest, ambivalence or passive reaction to infant - makes negative/hostile remarks to infant - handles infant in rough manner - disappointment over sex of infant - disappointment in appearance/behaviour
POSTNATAL	* - jealousy of attention given to infant - inappropriate response to baby's crying; feelings of helplessness, hopelessness, and not being loved - absence of nurturing behaviour - talking, holding, caring - perceives delivery as negative - expresses doubt regarding ability to care for infant - poor health status of parent	* - feeding difficulties - infant is irritable or difficult to console - infant with special needs - rigid or non-cuddly	* - does not comfort infant when crying, or heed physical needs - appears apathetic toward infant - negative verbalizations toward infant - repelled by messiness/ diaper changing - perceived by parent as being "different" - sex of infant remains unacceptable - negative identification of infant, by name or association, with someone disliked - does not enjoy playing with infant - delays naming infant

* Please refer to "Warning Indicators" previously listed.

WARNING INDICATORS FOR FAMILIES AT RISK

PERINATAL INDICATORS			
	PARENTING KNOWLEDGE, BELIEFS, EXPECTATIONS, PRACTICES	SUPPORT SYSTEMS	FAMILY CIRCUMSTANCES
NATAL	*	* - mother expresses hostility toward father who "put her through all this" - hostility/ obvious lack of support between couple- emotional isolation	*
POSTNATAL	* - unaware of infant's characteristics and abilities - sees infant as "demanding" or "manipulative" - unrealistic expectations persist for child and/or sibling - expresses fear of "spoiling" child	*	* - extremes of household organization/disorganization - frequent change of health care facility for vague reason - partner is not biological parent

* Please refer to "Warning Indicators" previously listed.

CAREGIVER/FAMILY INDICATORS		
CHARACTERISTICS PARENT(S)/CAREGIVER(S)	PARENT-CHILD ATTACHMENT	PARENTING KNOWLEDGE BELIEFS, EXPECTATIONS, PRACTICES
* - explanation regarding injuries is contradictory, inconsistent, projected on a third person, or lacking in history - parental preoccupation with self at child's expense - demonstrates poor impulse control when questioned about how they handle anger - externalizes blame for situation - little motivation/skill to effect changes in his life - unable to forego immediate gratification - resists initial attempt at discussion of child's condition/family situation - holds child responsible for parent's life difficulties and disappointments - domineering in attitude but emotionally weak - refuses consent for further diagnostic studies - cannot be located - shows fear of losing control or rigidity of behaviour with child and others - self-righteous to point of viewing child as "monster" or crazy - expresses dissatisfaction with present life situation	* - clings to child physically and emotionally - appears to "woo" child when together as though child were potential/actual lover - sees child as extension of self	* - parent has previously abused/neglected a child - shows little concern for child or what he is doing or failing to do - blames child - describes as "bad", "over-active", "defiant" - delays unduly in seeking medical or dental attention for child - reacts inappropriately to injury - discrepancy between verbal and non-verbal communication with child - treats other children in family differently - assumes child is at fault without waiting to learn the facts - discourages social contact of child with peers and other adults - encourages child to engage in sexual acts or behaviour - shows open hostility to child
* Please refer to "Warning Indicators" previously listed.		

CAREGIVER/FAMILY INDICATORS	
SUPPORT SYSTEMS	FAMILY CIRCUMSTANCES
*	* - uses child as "pawn" in adult conflicts

* Please refer to "Warning Indicators" previously listed.

CHILD INDICATORS *		
	PHYSICAL	BEHAVIOURAL
I N F A N T	* - poor weight gain - undernourished and/or dehydrated - frequent feeding and digestive disturbances (e.g., vomiting, diarrhea) - pallor - flaccidity - vaginal odour - vaginal bleeding/discharge - vaginitis - recurrent urinary tract infections - bruises/welts - human bites - burns - fractures - lacerations/abrasions - head injuries - poor physical hygiene (severe diaper rash, skin rashes, dirty hair, dirty hands and face, persistent body odour) - lethargic	* - no effort to feed self - no laughing, smiling, sociability - tense, wary, anxious, "vigilant" - no awareness of surroundings - repetitive behaviour e.g., rocking, head banging - shows behaviour different from that described by parent
	* Please refer to "Warning Indicators" previously listed.	

CHILD INDICATORS *		
	DEVELOPMENTAL	OTHER
I N F A N T	* - failure to thrive - growth delay - motor delay - developmental delay - delay in spontaneous vocalization - does not fixate on person/object by 3 months (visual defects excluded)	* - unattended physical problems or medical needs - routines poorly established (eating, sleeping) - other e.g., ingestions, Munchausen's By Proxy

* Please refer to "Warning Indicators" previously listed.

CHILD INDICATORS *		
	PHYSICAL	BEHAVIOURAL
P R E S C H O O L	* - chronic illness - fatigue, signs of sleeping problems - enuresis and encopresis in previously toilet trained child - poor, garbled or inappropriate speech, or mute - torn, stained, bloody clothing - pain, itching in throat, genital, rectal area - difficulty swallowing - difficulty with elimination - sitting/walking is difficult or painful - appears consistently hungry or thirsty - is in an unsafe environment - lack of appropriate supervision, abandonment - previously abused or neglected - given inappropriate food, drink or drugs * Please refer to "Warning Indicators" previously listed.	* - tends to resist changes in routines, or staff persons, or surroundings - noticeable mood or personality alteration - nervous habits (e.g., stuttering, tics) - resists participation in physical activity - aggressive/destructive behaviour, prolonged temper tantrums - begs, steals - behaviour inappropriate for age or situation - overly anxious to please and overly compliant - clings excessively, uses infantile behaviour - is attention-seeking, yet apprehensive or fearful of adult disapproval - fearful of physical contact with parents or other adults - poor social skills - little or inappropriate use of toys/play - detached or indifferent to discomfort or pain - poor impulse control with low tolerance to frustration - body language or facial expression suggestive of sadness, timidity, confusion, discouragement, depression, anger - apprehensive when other children crying - indiscriminate attachment to others, even strangers - resists undressing, becomes distressed when explaining an injury - drawings sexually explicit beyond developmental level - masturbates excessively - fears closed spaces - sex-role confusion - role reversal of parent and child - excessive concern regarding parents' needs - does not turn to parents for support-fearful of returning home

CHILD INDICATORS *		
	DEVELOPMENTAL	OTHER
PRESCHOOL	* - unusual interest in sex and uses terminology inappropriate for age	* - history of unexplained injuries or frequent bruising - has a non- biological parent - prolonged separation from parent (hospitalization, temporary placement) - social isolation - frequently absent from day care - isolated from regular observation in community - secrecy is prominent feature of family communication

* Please refer to "Warning Indicators" previously listed.

CHILD INDICATORS *		
	PHYSICAL	BEHAVIOURAL
S C H O O L A G E	* - squints constantly - aching teeth - pregnancy	* - drug/alcohol abuse - arrives early, stays late or reluctant to go home - eats other children's lunches, hoards own - falls asleep in class - inattentive, daydreams - suicide attempt - self-critical - gives up/won't try again - sets high self expectations - engages in delinquent behaviour - sudden onset of fears, phobias, stammering - promiscuity - runs away - prostitution

* Please refer to 'Warning Indicators' previously listed.

CHILD INDICATORS *		
	DEVELOPMENTAL	OTHER
S C H O O L A G E	*	* - sudden change in school performance - psychosomatic complaints - displays evidence of bribes - learning or concentration difficulties - states relationship with parent is poor - lunch is missing or inadequate

* Please refer to "Warning Indicators" previously listed.

INTERVIEWING THE FAMILY

INTERVIEWING

Many high risk families are unwilling or unable to discuss problems. This presents a particular challenge for the nurse. The first contact is critical and while it is not suggested that the nurse interview the parents and the child in each situation, the opportunity to do so may present itself. It is not the nurse's job to decide who did what, or when, or to pass judgment on the situation, but rather to gather information to make a professional assessment, and to offer support.

Some interviewing guidelines are offered below.

GENERAL GUIDELINES

DO

- conduct interview in a non-threatening private setting that is comfortable and informal
- use a calm, supportive and clear approach
- appear relaxed and non-threatening
- use an interested, concerned tone of voice
- use open-ended questions
- note non-verbal behaviour

DON'T

- be judgmental
- try to assign blame
- use accusatory questions and statements
- display horror, shock or anger at anything that is said
- allow personal feelings to interfere
- make negative remarks about the parent/caregiver

INTERVIEWING THE PARENT/CAREGIVER

DO

- listen with interest and concern
- indicate concern for the child
- accept what is said
- observe the parent's interactions with and tolerance of the child
- note the role the parent plays
- identify vague explanations or inconsistencies
- inform the parent regarding what you are going to do next and what might happen
- be professional, direct and honest

DON'T

- confront the parent
- be discouraged by defensive and resistant behaviour
- suggest explanations for the situation and/or events
- persist against resistance
- try to prove anything

INTERVIEWING THE CHILD

DO

- alleviate anxiety by discussing confidentiality, explaining what information must be shared and why
- recognize the difficulty in talking about the situation and reassure the child for doing so
- tell the child he is not alone and is not to blame
- use clear, understandable language
- use the child's own terminology
- allow the child to talk about the situation in his own way and only to the extent that he wishes
- minimize the necessity for the child repeating the story
- inform the child regarding what you are going to do next and what may happen

DON'T

- promise not to tell anyone
- make judgmental comments
- take sides or express allegiance
- be critical of parents
- insist that clothing be removed
- abandon the child to a stranger.

FAMILY ASSESSMENT

FAMILY ASSESSMENT

Family assessment is a critical component of the health care professional's job. It forms the basis by which a family can be identified before a risk situation or problem becomes a crisis. The following is a guide that can be used by the nurse to assist in an overall assessment of the family, its interactions, and its circumstances. What is provided is a list of areas to be considered in order to identify problems, set goals, and plan appropriate intervention.

FAMILY ASSESSMENT GUIDE

CHARACTERISTICS OF PARENT(S)

Background
- childhood experiences, religion, ethnicity, value system, losses, past relationships, history of abuse.

Physical Health Status
- past history of illness, level of wellness, physical limitations.

Psychological Status
- self-esteem, past and present coping mechanisms, substance use, mental health, presence of anxiety/fears, judgement, affect, behaviour toward child.

Developmental Level
- maturity, education, speaking and language ability.

Knowledge and Attitudes Regarding Childrearing
- understanding of: child's needs, growth and development, stimulation, discipline.

CHARACTERISTICS OF CHILDREN

Background
- wanted vs. unwanted, birth order, single or multiple birth, perinatal history.

Physical Health Status
- past history of illness, level of wellness, physical limitations, birth defect, medically diagnosed injuries, observable injuries, medical care, hygiene, sensory skills.

Psychological Status
- self-esteem, past and present behaviour, presence of anxiety/fears, affect, substance abuse, perceptual skills.

Developmental Level
- age appropriate, school performance.

FAMILY INTERACTIONS

Roles
- role allocation, age appropriateness, flexibility, coverage of all necessary family roles, role changes, role conflicts, role expectations.

Communication
- verbal vs. non-verbal, direct vs. indirect, masked vs. clear, listening skills.

Problem-Solving
- past and present ways of dealing with affective and instrumental problems.

Emotional Climate

- presence or absence of: warmth, acceptance, trust, cohesion, expressiveness, conflict, scapegoating, emergency feelings such as fear and threat.

Attachments
- affective involvement between family members, e.g., lack of involvement or over-involvement.

SUPPORT SYSTEMS

Accessibility/Acceptance/Use

Internal
- family members, faith, individual strengths.

External
- church, community, relatives, recreation, agencies.

FAMILY CIRCUMSTANCES

Housing
- adequacy of space, privacy, safety, environment.

Finances
- source, adequacy, disbursement.

Other
- employment, marital status, legal status.

REPORTING

REPORTING

Individuals and health care professionals have a moral and a legal duty to report a concern of suspected child abuse or neglect. It is not necessary to have proof that abuse or neglect has occurred or will occur, only reasonable grounds to suspect abuse or neglect. By reporting, a statement is being made that a child may be abused or neglected, not that certain parents are child abusers.

It is not up to the reporter to verify whether abuse has occurred. This responsibility belongs completely to the Children's Aid Society. A report should be seen as a request for the process of help to begin, and as the legal basis for intervention on the child's behalf.

If civil action is brought against a person who made a report, she will be protected from liability unless the report was made maliciously, or without reasonable grounds. The onus to report is clearly on the person who suspects; disagreement with a supervisor, a physician, a principal or any other person does not relieve one of that obligation.

UNACCEPTABLE REASONS FOR NOT REPORTING

Numerous reasons are given for not reporting a suspicion of child abuse or neglect even when an individual is aware of her legal responsibility. Some of the most common reasons are:

1. Fear and uncertainty of the legal implications, parental retaliation, placing the child at increased risk, and making the family situation worse.

2. Lack of information about the problem and/or how to proceed.

3. Denial of the facts. It is sometimes difficult to put aside a feeling that "this isn't really a problem" or that "the child deserved to be punished".

4. Uncertainty as to the outcome of a report. The reporter may believe that nothing will be done and therefore there is no point in becoming involved. This belief could be due to lack of knowledge or to previous experience with the Children's Aid Society. However, if a report is NOT made, NOTHING will be done.

5. Other professionals may interfere with reporting. As has been previously mentioned this does not relieve the individual who suspects abuse/neglect of her legal responsibility.

6. The presence of emotional ties with the family and a feeling that a report would represent a betrayal of trust. Being honest and supportive with the family will minimize this problem and augment an ongoing relationship.

No reason is acceptable for not fulfilling the legal and moral responsibility to report suspicion of child abuse and neglect. Only through involvement and referral can we hope to assist these families to become more positive in their relationships.

NOTIFYING PARENTS OF A REPORT

The law does not require that a parent be notified that a report is to be made or has been made to the Children's Aid Society. However, most professionals believe that parents have a right to know, and that being honest and direct with them initially, provides an opportunity to express concern, and to foster an ongoing relationship.

In specific situations one must NOT inform the parent that a report is being made. These are:

- cases of intra-familial sexual abuse
- cases of serious physical injury when the parent is not immediately available
- cases when it is suspected that the family will "disappear" before the Children's Aid Society can make contact
- cases when it is believed that the child may receive further abuse before the investigation can begin.

The primary consideration must always be the safety of the child.

A parent may react with anger initially. The reporting person must be prepared to help him understand that the report is made out of concern and is in fact an attempt to obtain help for the family. This provides an opportunity to present the Children's Aid Society in a positive manner and to interpret some of the services that may be available.

THE ROLE OF THE POLICE

The police have a valuable role to play, both legally, and as part of the team, in the investigation and management of child abuse cases. Often in large urban centres, the police have assigned specific officers to deal with child abuse. For example, the Metropolitan Toronto Police Department has staff specially trained to work with children and their families in this area. The police are very important partners in the investigation of serious physical abuse, and all cases of sexual abuse, and are notified of these situations by the Children's Aid Society. In certain cases they may consider laying charges under the Criminal Code of Canada. Not all police investigations lead to the laying of charges.

Standards and Guidelines have been set by the Ministry of Community and Social Services in the area of police involvement. The first standard reads:

> A plan shall be developed jointly by the local Children's Aid Society and the police to ensure that there is a cooperative working agreement. This working agreement will include plans for the mutual sharing of information of complaints of suspected child abuse (5).

Further:

> At the time of notification and consultation, a decision will be made regarding the most appropriate and effective means of investigation.
>
> Possibilities are:
>
> a) investigation by the Children's Aid Society
> b) parallel Children's Aid Society/police investigation
> c) joint Children's Aid Society/police investigation (6).

As well as the Ontario Standards and Guidelines many jurisdictions have developed inter-disciplinary procedures, or 'protocols' which outline specific roles and duties of those professionals involved in child abuse investigations and/or case management. For example, Metropolitan Toronto has the Child Sexual Abuse Protocol which was prepared by the Metropolitan Toronto's Special Committee on Child Abuse in November 1983 and revised in 1986. This protocol very clearly delineates the joint role of the police and the Children's Aid Society in response to child sexual abuse.

REPORTING PROCEDURE

I RELEVANT LEGISLATION

Definition of "Child"

"A Child" is defined as being under sixteen years of age, or under eighteen years of age, if he is either a ward of the Children's Aid Society or the subject of a supervision order under the Children's Aid Society. This is consistent with the legal definition found in the Child and Family Services Act, 1984, Section 3(1)6 and Section 37(1)(a).

Child in Need of Protection

The Child and Family Services Act, 1984, Part III - Child Protection states in:

Section 37 (2) A child is in need of protection where,

*(a) the child has suffered physical harm, inflicted by the person having charge of the child or caused by that person's failure to care and provide for or supervise and protect the child adequately;

(b) there is a substantial risk that the child will suffer physical harm inflicted or caused as described in clause (a);

*(c) the child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child;

(d) there is a substantial risk that the child will be sexually molested or sexually exploited as described in clause (c);

*(e) the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment;

*(f) the child has suffered emotional harm, demonstrated by severe,

(i) anxiety,
(ii) depression,
(iii) withdrawal, or
(iv) self-destructive or aggressive behaviour,

and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm;

(g) there is a substantial risk that the child will suffer emotional harm of the kind described in clause (f), and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm;

*(h) the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to

consent to, treatment to remedy or alleviate the condition;

(i) the child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody;

(j) the child is less than twelve years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment;

(k) the child is less than twelve years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately; or

(l) the child's parent is unable to care for the child and the child is brought before the court with the parent's consent and, where the child is twelve years of age or older, with the child's consent, to be dealt with under this Part.

*The Child and Family Services Act, 1984, defines "abuse" as referring to subsections (a),(c),(e),(f) and (h).

Duty To Report

The Child and Family Services Act, 1984, further states in:

Section 68

(2) A person who believes on reasonable grounds that a child is or may be in need of protection shall forthwith report the belief and the information upon which it is based to a society.

(3) Despite the provisions of any other Act, a person referred to in subsection (4) who, in the course of his or her professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information on which it is based to a society.

(4) Subsection (3) applies to every person who performs professional or official duties with respect to a child, including,

(a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;
(b) a teacher, school principal, social worker, family counsellor, priest, rabbi, clergyman, operator or employee of a day nursery and youth and recreation worker;
(c) a peace officer and a coroner;
(d) a solicitor; and
(e) a service provider and an employee of a service provider.

(5) In clause (4) (b), "youth and recreation worker" does not include a volunteer.

(6) A society that obtains information that a child in its care and custody is or may be suffering or may have suffered abuse shall forthwith report the information to a Director.

(7) This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with subsection (2) or (3) unless the person acts maliciously or without reasonable grounds for the belief or suspicion, as the case may be.

Offences

Section 81 (1)(b)

A person who contravenes, subsection 68 (3) (reporting child abuse); and a director, officer or employee of a corporation who authorizes, permits or concurs in such a contravention by the corporation is guilty of an offence and on conviction is liable to a fine of not more than $1,000.

II WHEN AND WHERE TO REPORT

A report must be made to an intake worker of the Children's Aid Society when there is reason to suspect abuse, deprivation or neglect. In most jurisdictions there is only one Children's Aid Society, but in some there are sectarian agencies responsible for child welfare. In Metropolitan Toronto, Catholic families should be referred to the Catholic Children's Aid Society, Jewish families to the Jewish Family

and Child Service Agency, and all others to the Metro Children's Aid Society.

If religious denomination is unknown, the report may be made to either Children's Aid Society, which will accept the call and sort out responsibility about religion.

Each staff member should be familiar with the telephone numbers of the local Children's Aid Society. These numbers operate on a twenty-four hour basis.

Note: It is not up to the person reporting suspected abuse to determine whether abuse in fact exists. That responsibility rests entirely with the Children's Aid Society.

III WHAT TO REPORT

Be prepared to provide the Children's Aid Society with the following information, if available:

(i) Identifying Information

- Child - name, age, sex, address and telephone number, present whereabouts
- Family - names, addresses, telephone number (including business number), present whereabouts
- Siblings- names, ages, addresses, schools
- Names, addresses and telephone numbers of other persons/agencies having relevant information.

(ii) Nature of Suspected Abuse

- Physical and Behavioural Indicators (refer to Warning Indicators For Families At Risk and Documentation Guidelines)
- If parent has been informed, his reaction to your suspicion and your intent to report
- Child's reaction to your suspicion and your intent to report
- Opinion regarding urgency
- Child's present condition (physical, emotional, safety issues).

(iii) Professional Information

- Name, address, phone number
- Professional duties that led to concern
- Length of time family known
- Action taken prior to report
- Plans for future involvement, if any.

IV HOW TO REPORT

1. Gather and organize all available pertinent data (e.g., information from principal, teachers, siblings, child's caregiver, etc.).

2. If appropriate, discuss with the parents the concerns regarding the situation, your responsibility to report, and the assistance they can expect from the Children's Aid Society. IN CASES OF INTRA-FAMILIAL CHILD SEXUAL ABUSE AND IN SOME OTHER SITUATIONS, THIS DISCUSSION SHOULD NOT TAKE PLACE (see page 59).

3. Immediately contact your supervisor/delegate regarding your suspicions and your intent to report. If the supervisor is unavailable, do not delay your report for this reason, but inform the supervisor as soon as possible.

4. If the concern arises while you are in the school, report your concern to the principal who may take the responsibility of notifying the Children's Aid Society. However it is your responsibility, as the person who suspects the abuse, to ensure that the report is made.

5. If the concern is not shared by your supervisor and/or the principal, it remains your professional responsibility to report your suspicions immediately.

6. Phone the report to the appropriate Children's Aid Society.

7. Record all information on the family record and, if applicable, on the school health record (see Documentation Guidelines).

8. Prepare a written report, confirming and expanding on the referral, and forward it, with a supervisor's covering letter, to the Children's Aid Society, within a maximum of two weeks.

V CLIENT THREATS

Any threat made by a client towards you, the informant, or another involved party, must be documented and reported to the Personal Health Services Supervisor, and the Children's Aid Society. A decision to report the threat to the police should be made on an individual basis.

DOCUMENTATION GUIDELINES

DOCUMENTATION GUIDELINES

Documentation is a responsibility of all health care professionals. It becomes vital in cases of suspect child abuse and neglect when at any given time the family record may become court evidence. The nurse's testimony can only be valuable if it is based on well documented observations and events. For this reason detailed documentation guidelines are presented.

GENERAL GUIDELINES

- Documentation should be: specific
  objective
  up-to-date

- Document only what is observed or heard.

- Entries must be made for every contact with, or on behalf of the client including:

  - telephone calls
  - home visits
  - telephone calls not found
  - home visits not found
  - consultations and discussions regarding the case with others
  - contacts with agencies/workers/resources.

- First entry by any person must have full signature and title.

- Subsequent entries require initials only.

- Entries must be made within 24 hours of contact.

- Do not alter record. Use of whiteout is not acceptable. If an error is made, use proper nursing procedure to correct it i.e.,

  (i) cross out error (1 single line through it);
  (ii) write "error" above it;
  (iii) initial it.

- All records are to be hand-written. Specifics such as measurements, verbatim statements, observations, etc. can be recorded directly onto the Continuation Sheet of the record at the time of the contact. Any empty spaces should have a line drawn through them.

- In all high-risk situations, the record is to be made permanent.

SPECIFIC GUIDELINES

I Identifying Information

II Contacts

- Date and time of visit and who was present.
- Date and time of telephone call and person spoken to.
- Date and time of recording.
- Date and time of report to Chilren's Aid Society and name and title of person receiving the report.

III Assessment

The following areas for assessment are not presented in a specific order, and are guidelines for documentation, only in those areas assessed. These areas are not to be assessed in every situation BUT only when appropriate, i.e., where there is concern.

Patterns of observations, measurements or behaviours should be documented on the Individual Profile Sheets. Ongoing observations, measurements or behaviours should be documented on the Notes.

- Physical Examination
  - absence/presence of anomalies, cuts, bruises, burns, welts or other signs of trauma
  - size, shape, location, colour, appearance (description should be clear enough so that injury can be easily visualized)
  - the Diagram of Body Outline may be helpful. These will be provided in each District Office and their use is optional
  - parental explanation of injury.
- Basic Hygiene Measures and Appropriateness of Clothing (with respect to child's basic needs).
- Physical Growth
  - age, weight, height, head circumference (for children under 2 years old)
  - Where there is a concern, record on growth charts provided in each District Office. These should be kept in the Family File Folder. Disposable tape

measures will be available in each District Office for use, as necessary.

- Nutritional Status

  - food intake for 24 hour period
  - comparison to basal caloric and food requirements for child's age, weight and body surface area (consult with Area Nutritionist)
  - if opportunity arises, it may be possible to observe food supplies in cupboards and refrigerator.

- Development

  - milestones - achievement/delay
  - age-specific behaviour
  - tools used for assessment.

- Behaviour

  - absence/presence of any behavioural characteristics indicative of risk.

- Parent-Child Interaction

  - parent's response to child-initiated interactions
  - child's response to parent-initiated interactions.

- Social Interaction

  - child's interaction with nurse, others in home, others in his environment (eg., peers, teachers).

- Child Care

  - caregiver's knowledge of child care (expressed and/or demonstrated)
  - caregiver's expectations of child
  - appropriateness of alternative child care arrangements (i.e., in absence of primary caregiver).

- Home Environment and Safety

  - presence/absence of hazards - nature of space (i.e., overcrowding, bed space, room for play, etc.).

- Health History

  - child - prenatal and neonatal history
    - illnesses/accidents
  - other family members - illnesses/accidents
    - substance abuse.

- Family History

  - stressful life events and family's response to stress
  - childrearing experienced by parents i.e., in their childhoods
  - history of family violence.

IV Nursing Diagnosis

V Plan

VI Intervention/Action

VII Evaluation

CASE MANAGEMENT

CASE MANAGEMENT

In dealing with high risk families, the objective should be to help both the parents and the child. It is important not only to interrupt the negative pattern of behaviour, but also to deal with the emotional conflicts that have produced the behaviour within the family. Steele and Pollock state that the goal of treatment in terms of a growth process is to help the parents "grow out of their isolated, trapped, hopeless pattern of living into a sense of self-esteem and to develop an ability to find enough gratification in the adult world so that they can become loving and giving to their children" (7). The ultimate objective of intervention is to alter the quality and quantity of parent-child interactions towards a more positive relationship.

Establishing and maintaining good client relationships is a challenging part of the nurse's work. High risk parents need the time and attention of the nurse, and the opportunity to be listened to. This helps them build the needed sense of confidence and lays the foundation for developing a sense of self-respect and identity. The nurse's recognition of parents' needs, the willingness to help find ways to satisfy such needs, and the acceptance of less than perfect performance, enable the parents to develop new techniques of coping and a greater sense of self-esteem. Empathy, respect and predictability are important qualities for health professionals to possess to promote trust and credibility with their clients.

The problems of a high risk family are multiple and varied and therefore there is a need for a multidisciplinary approach. No one discipline nor one person can provide all the necessary services and resources to these families. It is imperative that all those involved in providing service maintain an open communication.

One of the major tasks of the health professional is deciding how best to intervene to help the high risk family. Individual/family counselling is only one possible process. No one strategy or approach is effective all the time and the nurse needs to have a selection of strategies available that can be used alone or in combination. What we have attempted to do is to summarize some strategies for intervention when the family is being dealt with on an individual basis. We recognize many other valuable methods of management such as groups for mothers and children, parent-education groups, family advocacy, day care and many more.

The criteria of successful intervention with these families are not easily identified and vary from situation to situation. Two of the most important signs of improvement are: a reduction in demand upon, and criticism of children, and recognition of a child as an individual with age-appropriate needs and behaviour. Other things to consider include: have the parents demonstrated both a willingness and an ability to use others in time of need? are they developing out-of-home interests? have their self-images improved? do they recognize immediate and pending crises and know how to handle them or how to get help? has the child's "provocative" behaviour been modified? and, has the relationship between the parents and nurse developed to the point of trust and confidence? The final step, of course, is that the family becomes independent of the health care professional.

PROFESSIONAL SELF-AWARENESS

In establishing and maintaining therapeutic relationships, the nurse must be constantly aware of the feelings that are generated within her by these families. She must acknowledge and come to terms with her own feeling about neglectful and abusive situations. This self-awareness facilitates objectivity and allows the nurse to separate the individual from his behaviour. Working with high risk families is time consuming and demanding.

The necessity of receiving ongoing peer and supervisory support cannot be overemphasized. At times the nurse must recognize that she can no longer be therapeutic and must refer the case to another professional.

CASE MANAGEMENT STRATEGIES

GENERAL GUIDELINES

- Acknowledge your own cultural heritage
- Avoid prejudice and cultural bias
- Avoid cultural and language barriers

STRATEGY	ASSESSMENT	INTERVENTION
CRISIS INTERVENTION	Assess whether the client is in crisis. A crisis is a state of disequilibrium when internal coping strengths and external supports are lacking and a problem remains unresolved with increasing anxiety. Crises can result either in complete immobilization or new growth.	
	• Observe for symptoms - appearance - behaviour - rising tension and disorganization.	• Respond in terms of the present problem.
	• Identify the precipitating event(s).	• Clarify the problem relating the precipitating event(s) and the present crisis state.
	• Determine crisis onset.	
	• Identify client's perception of the problem.	• Provide opportunities for expression of emotions.

CASE MANAGEMENT STRATEGIES

STRATEGY	SPECIFIC SUGGESTIONS
CRISIS INTERVENTION	• Ask about recent changes in daily activities. • Ask when the feeling of "tension" was first noticed and what occurred at that time. • Ask about recent life events e.g., job change, loss of job, death in family, new baby, etc. • Ascertain when the precipitating event caused the crisis. • Ascertain why the precipitating event provoked a crisis. • Ask what the event means to them and how they think it will affect their future.

CASE MANAGEMENT STRATEGIES

STRATEGY	ASSESSMENT	INTERVENTION
CRISIS INTERVENTION	• Determine situational supports.	• Provide support and mobilize other support systems.
	• Identify past coping mechanisms.	• Test alternative coping mechanisms.
	• Assess homicidal or suicidal risk.	• Mobilize mental health and/or medical resources as necessary.
	• Assess any disruption in family.	• Determine the degree of disruption in the family.
	• Determine coping methods that seem feasible or have worked well in the past.	• Reinforce successful coping mechanisms. • Help client define realistic options available.
	• Observe for signs of resolution.	• Determine resolution of the problem.
RELATIONSHIP	• Assess client's acceptance of a helping relationship. Observe for resistant behaviours e.g., denial, hostility, passivity, non-cooperation, sabotaging.	• Use a family-centred approach when possible.

CASE MANAGEMENT STRATEGIES

STRATEGY	SPECIFIC SUGGESTIONS
CRISIS INTERVENTION	• Ask about friends/relatives/ neighbours. • Ask whom they trust and turn to when they have problems. • Determine any other professionals involved. • Ask about similar past experiences and what they did then. • Ask how they deal with tension and stress. • If potential for suicide/homocide is suspected then ask direct questions about thoughts the client may have. • Determine effect of the crisis on significant others. • Support client strengths and adaptive responses. • Explore how present resolution may help with future crises and coping abilities.
RELATIONSHIP	• Include family members in development of goals and acknowlege their viewpoint as important. • Approach family members as independent rather than dependent on the health care professional. • Incorporate parents' experiences into planning.

CASE MANAGEMENT STRATEGIES

STRATEGY	ASSESSMENT	INTERVENTION
RELATIONSHIP	• Determine potential nurse - client differences. • Assess family experiences and needs. • Assess patterns of family interaction.	• Contract with the client. • Establish a trust relationship. • Be a positive role model. • Plan termination.
COMMUNICATION	• Assess the communication skills of family members both internally and externally. • Identify any communication barriers.	• Be a good listener. • Help the family develop better communication skills.

CASE MANAGEMENT STRATEGIES

STRATEGY	SPECIFIC SUGGESTIONS
RELATIONSHIP	• Establish agreement about problems, goals, techniques, roles and tasks. • Modify contract as necessary. • Be honest and explicit. • Respect confidentiality. • Follow through on tasks and time limits. • Focus on communication, positive reinforcement, realistic expectations, parenting. • Establish time limits for working on goals. • Provide information about additional resources.
COMMUNICATION	• Initially encourage conversation on any topic, if necessary. • Use silence to allow client to think and respond. • Use open-ended questions. • Clarify client's statements e.g.,"I'm not sure what you meant by...." • Point out incongruities. • Assist clients with recognizing when messages do not seem to be understood. • Point out non-verbal messages. • Help client to name feelings.

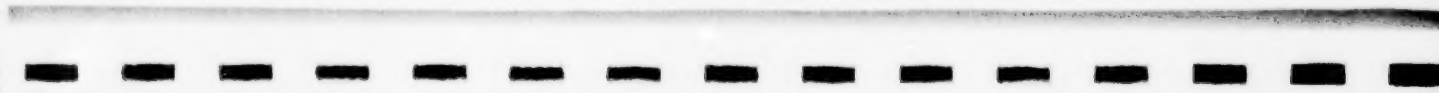
CASE MANAGEMENT STRATEGIES

STRATEGY	ASSESSMENT	INTERVENTION
COMMUNICATION		• Provide new information. • Use positive reinforcement. • Use confrontation and feedback when appropriate.
PROBLEM SOLVING	• Define the problem. • Determine goals related to the problem.	• Select one or two solvable problems. • Discuss all possible alternatives and consequences of each. • Decide on an approach to try. • Evaluate the outcome. • Make future plans.
TEACHING	• Assess readiness to learn. • Assess client's needs, abilities and strengths.	• Build upon previous knowledge. • Individualize teaching. • Model behaviour. • Use positive reinforcement. • Build on family's strengths. • Evaluate the desired learning.
PERSONAL	• Assess your own feelings about working with the family. • Assess your strengths and weaknessess in each situation. • Assess your level of "burn out".	• Make appropriate referrals. • Be responsible, not omnipotent. • Seek supervision and support. • Develop personal methods for coping.

CASE MANAGEMENT STRATEGIES

STRATEGY	SPECIFIC SUGGESTIONS
COMMUNICATION	• In high risk situations provide information in very small units. • Offer suggestions or options rather than advice. • Give positive reinforcement, verbally or non-verbally. • Assist the client to recognize behaviour and problems by providing feedback. • Use open-ended phrases NOT questions.
PROBLEM SOLVING	• Build on family strengths. • Decide on an approach specifying what will be done, by whom and when • Modify the environment and make referrals as necessary. • Focus on the achievement of goals and the methods used to meet them.
TEACHING	• Include significant others in the teaching.
PERSONAL	• Be aware of your own limitations and those of the family. • Be aware that set backs and further problems may occur. • Maintain a realistic workload.

COURT - CHILD WELFARE MATTERS



COURT - CHILD WELFARE MATTERS

With every case of child abuse and neglect the health care professional should be prepared for the possibility of a court hearing. It should be determined which Provincial Court Division (Criminal or Family) will hear the case. It is possible that different aspects of the case may be heard in both Divisions.

Criminal prosecutions are initiated by the police in response to the more serious cases. The function of the Criminal Division is to determine the innocence or guilt of the accused and to protect his/her legal rights; the Family Division's jurisdiction is concerned with the protection of the child.

Initiation of court proceedings results in a court hearing. Hearings in Family Division may be adjourned for up to 30 days with the possibility of many subsequent adjournments. This means that the witness may be required to make several appearances before the testimony is actually given. When an adjournment occurs the court must determine interim care and custody for the child. Four options exist:

1. the child remains with the parent(s);
2. the child remains with the parent(s) and there is a supervision order to the Children's Aid Society with or without conditions;
3. the child stays with some other person and there is a supervision order to the Children's Aid Society;
4. the child is cared for by the Children's Aid Society

The thought of giving testimony can be anxiety producing, and certainly the actual court appearance can be stressful. Being prepared for both direct and cross examination is perhaps the best way to alleviate some of the concern. Direct examination is the initial line of questioning focusing on eliciting pertinent

facts from the witness. Cross examination gives the opposing party's lawyer an opportunity to question what the witness has said in order to try and discover any untruths or weaknesses in the testimony.

Valuable preparation for the court hearing includes discussion of testimony with the appropriate lawyer responsible for the subpoena. The lawyer could alert the witness to possible objections and to areas where the testimony is vulnerable. It is important to be familiar with all the facts documented in the family record in order that a description of the contact(s) with the parent(s) and/or child may be presented. Testimony may also include any observed interaction between parent(s) and child. Hearsay evidence, i.e., evidence not based on the witness's personal knowledge, is not admissible in a court of law. Testimony on neighbours', teachers', day care workers', or other professionals' perceptions of the situation, may be considered hearsay evidence and therefore not admissible. It is up to the judge or counsel to decide whether the testimony offends the hearsay rule, as there are many exceptions.

Once the hearing occurs and there is a finding of a "child in need of protection" the court then has the right to make an order. Again, four options exist:

1. supervision order whereby the Children's Aid Society oversees the parent(s)' care of the child;
2. period of Children's Aid Society wardship;
3. period of Children's Aid Society wardship followed immediately by a supervision order;
4. crown wardship.

As a witness, the health care professional has pertinent information to contribute to court proceedings and with careful documentation and preparation the testimony given can be valuable

in planning for the ongoing care of the child and family. This plan may include a continued role for the health care professional.

APPEARANCE IN PROVINCIAL COURT

I RECEIVING A SUBPOENA

If a person is required to give testimony in Criminal Division, a subpoena is issued; for Family Division, a summons is issued. In the following guidelines the word subpoena has been used to denote either summons or subpoena.

- The supervisor should be informed if the staff person becomes aware that a subpoena will be served, or if a subpoena has been served.
- Receipt of a subpoena does not preclude continued nursing involvement with the family under investigation.
- A subpoena requires that the person named appear in court at a specified time to give evidence for either the Crown or the defence.
- Failure to obey a subpoena is a criminal offence (contempt of court) and is subject to a fine or imprisonment.
- There is no minimum length of time required between the serving of a subpoena and the requested date of appearance in court.
- The subpoena may be personally accepted by someone else on behalf of the named person.
- Once a person has been served with a subpoena, she may be called on at any time as long as the specified case is in court. The witness should ascertain from the judge or counsel at the end of each day if it is

necessary to return to court. The length of time that the witness must be available for appearance may vary from one day to several months.

- The subpoenaed person is free to, but not legally obliged to, discuss the case with other lawyers involved in the case.

- If the record is required as evidence, this must be specified in the subpoena. Only then may the written contents of the record be shared with the person who initiated the subpoena.

II REQUEST FOR INFORMATION WITHOUT A SUBPOENA

- If information is requested without a subpoena, the request must be in writing to the Associate Medical Officer of Health, stating the specific information sought. The request must be accompanied by a signed release of information from the child's legal guardian.

- Written communication regarding a case must be reviewed by the supervisor before being sent.

III PREPARING FOR COURT

- Request a meeting with the lawyer responsible for the subpoena to review and discuss the presentation of evidence.

- Be prepared to provide a brief verbal description of your educational and professional background to establish credibility as a witness.

- Expect to be questioned regarding your professional opinion of the situation.
- Review the family record to become familiar with the sequence of events and the evidence therein.
- Anticipate potential questions.
- Role play the testimony (e.g., with supervisor).
- Review your testimony with Departmental personnel who have had court experience in order to receive support and clarify testimony (e.g., supervisor, mental health nurse, other public health nurses).
- Remember that you are protected against legal action when giving confidential information as evidence.
- In some cases the supervisor may attend court with the staff person; make arrangements for this as soon as the court dates are known.

IV SUGGESTIONS FOR TESTIFYING

- Remember: you are not the one on trial!
- Appear relaxed and calm.
- Speak clearly; answer questions in a confident manner; you may use notes or the family record to refresh your memory, if the Court agrees.
- Speak more loudly than you would in normal conversation; speak in an even tone of voice; take your time.

- Give direct, honest answers, keeping them brief and to the point.
- Direct answers to the judge, maintaining eye contact.
- Avoid jargon and professional terms.
- Give first person evidence.
- Avoid vague answers such as, "I guess....".
- Listen to each question and be sure that you understand it fully. If you do not, ask for clarification, rewording the question to your own understanding, e.g., "Do you mean....?"
- Do not feel compelled to respond "yes" or "no", you may say "I do not know".
- Set your own pace. Do not allow the counsel to rush or intimidate you; be alert to questions or statements that may lead you to alter your testimony inadvertently.
- Do not get angry or defensive. The line of questioning should not be interpreted as a personal attack.
- Do not eat or chew gum. You may accept a glass of water.

V COURT ORDERS

- Under the Child and Family Services Act, 1984, no provision has been made for the Department of Public Health to be the recipient of a court order.

- If such an order is made the staff person is to consult her supervisor immediately. Further consultation may then be required from the City Solicitor.

VI AFTER THE COURT APPEARANCE

- Report to the Personal Health Services Supervisor when the case has concluded.
- Record the specifics of the case on the family record: i.e., dates and time spent in court; a summary of the testimony given; the outcome, if known.
- Give any cheques for witness fees to the Business Manager for deposit in the City Treasury.
- The original family record is the property of the Department and must be returned at the conclusion of the court hearing.
- Verified photocopies of the original record can be taken and left with the judge at the request of the court, if all parties agree and the original is available on request.

VII DEALING WITH THE MEDIA

- Do not give statements to the media regarding the case.
- Refer the press to the Medical Officer of Health or a designated other.

RESOURCES

RESOURCES

CHILDREN'S AID SOCIETIES

Catholic Children's Aid Society
26 Maitland Street
Toronto, Ontario
M4Y 1C6
925-6641 (24 hours)

Jewish Family and Child Service
of Metropolitan Toronto
4600 Bathurst Street
Toronto, Ontario
M2R 3V2
638-7800 (24 hours)

Metropolitan Toronto Children's Aid Society
33 Charles Street East
Toronto, Ontario
M4Y 1R9
924-4646 Emergency After Hours 924-5334

OTHER RESOURCES

Alliance For Children
234 Eglinton Avenue East
Suite 401
Toronto, Ontario
M4P 1K5
489-0710

Child Abuse Referral and Information - Community Information
863-0505

Hospital For Sick Children S.C.A.N.
(Suspect Child Abuse and Neglect) Program
555 University Avenue
Toronto, Ontario
M5G 1X8
598-6275 (24 hours)

Justice For Children
720 Spadina Avenue
Suite 105
Toronto, Ontario
M5S 2T9
920-1633

Metropolitan Toronto Special
Committee on Child Abuse
443 Mount Pleasant Road
2nd Floor
Toronto, Ontario
M4S 2L8
440-0888

Ministry of Community and Social Services
Children's Services Division
2195 Yonge Street
Toronto, Ontario
M4S 2B2
965-1433

National Clearinghouse on Family Violence
Brooke-Claxton Building
Tunney's Pasture
Ottawa, Ontario
K1A 1B5
(613) 995-1050

Office of the Official Guardian
Ministry of the Attorney General
180 Dundas Street West
Toronto, Ontario
M5G 1E9
965-1865

Ontario Centre for the Prevention of Child Abuse
25 Spadina Road
Toronto, Ontario
M5R 2S9
965-1900

AUDIO-VISUAL RESOURCES

L.M. Media Marketing Services Ltd.
115 Torbay Road
Unit 9
Markham, Ontario
L3R 2M9
475-3750

National Film Board
Mackenzie Building
1 Lombard Street
Toronto, Ontario
M5C 1J6
973-4093

RESOURCE DIRECTORIES

Audio Visual Resources on Child Abuse
Ontario Ministry of Community and Social Services
February 1984

Child Sexual Abuse Treatment Resource Directory
The Metropolitan Chairman's Special Committee
on Child Abuse
March 1984

Child Sexual Abuse Resource Materials for
Preventive Education
The Metropolitan Toronto Special Committee on
Child Abuse
July 1986

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LOCAL RESOURCES

Resource	Contact Pers	Phone Number

FOOTNOTES

FOOTNOTES

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(2) N. Polansky, C. Hally, and N. Polansky, Profile of Neglect (U.S. Department of Health Education and Welfare, Social and Rehabilitation Service, 1973).

(3) Ruth S. Kempe, Christy Cutler, and Janet Dean, "The Infant with Failure-to-Thrive," in The Battered Child ed: C. Henry Kempe and Ray E. Helfer (Chicago: Univeristy of Chicago Press, 1980), p. 164.

(4) Joyce N. Thomas and Carl M. Rogers, "Sexual Abuse of Children: Case Finding and Clinical Assessment, " The Nursing Clinics of North America 16 (March 1981): 179-188.

(5) Government of Ontario, Standards and Guidelines. Child Abuse (Ministry of Community and Social Services. Children's Services Division, February 1981), p.34.

(6) Ibid.

(7) B.F. Steele and C.B. Pollock, "A Therapeutic Approach to the Parents," in The Battered Child ed: Ray E. Helfer and C. Henry Kempe (Chicago: University of Chicago Press, 1968), p.14.

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